St. Peter's Hospital

2475 Broadway ı Helena, Montana 59601

Employment Application

NAME (LAST, FIRST, M.I.)		
POSITION APPLIED FOR	POSITION APPLIED FOR	POSITION APPLIED FOR
DATE	DATE	DATE

AN EQUAL OPPORTUNITY EMPLOYER

It is the policy of St. Peter's Hospital to provide equal employment opportunity. Selection of applicants shall be made on the basis of their qualifications and ability to perform the job, without regard to race, color, religion, sex, national origin, age, marital status or the presence of a disability that does not interfere with the performance of the essential functions of the job applied for.

PLEASE PRINT PLAINLY

All Applicants Must Complete Entire Application

PERSONAL INFORMATION

NAME (LAST, FIRST, M.I.) | SOCIAL SECURITY NO.

HAVE YOU EVER BEEN EMPLOYED UNDER ANOTHER NAME? IF YES, PLEASE LIST AND WHEN

☐ YES ☐ NO

PRESENT ADDRESS (STREET NO.) | CITY, STATE | ZIP CODE | HOW LONG?

IF AT PRESENT ADDRESS LESS THAN SIX MONTHS, GIVE PREVIOUS ADDRESS | HOW LONG?

TELEPHONE NUMBER | RELATIVES EMPLOYED IN THIS FACILITY?

☐ YES ☐ NO DEPARTMENT

ARE YOU A U. S. CITIZEN?

POSITION(S) APPLIED FOR | HOW DID YOU LEARN ABOUT THIS JOB OPENING?

DO YOU PREFER: ☐ FULL TIME ☐ PART TIME | DAYS AVAILABLE | HOURS AVAILABLE _____ First Choice _____ Second Choice

WHEN WOULD YOU BE AVAILABLE FOR WORK? | WERE YOU PREVIOUSLY EMPLOYED BY US? | WHEN?

ARE YOU ABLE TO PERFORM THE ESSENTIAL FUNCTIONS OF THE JOB FOR WHICH YOU ARE APPLYING.

HAVE YOU BEEN CONVICTED OF A FELONY? IF YES, EXPLAIN. (A felony conviction does not automatically disqualify you from employment)

☐ YES ☐ NO

EDUCATION

TYPE OF SCHOOL	NAME AND ADDRESS	FROM	TO	DEGREE	COURSE OR MAJOR
HIGH SCHOOL					
COLLEGE					
POST GRADUATE					
BUSINESS OR TRADE					
OTHER					

OFFICE MACHINES YOU OPERATE PROFICIENTLY:

LIST ANY SPECIAL CERTIFICATES AND/OR TECHNICAL PROFESSIONAL LICENSES: | TYPING SPEED | SHORTHAND

HAVE YOU EVER BEEN BONDED? | WHEN AND WHERE?

Please use the space below to summarize any additional information necessary to describe your full qualifications.

Did you serve in the U. S. Armed Forces? ☐ Yes ☐ No What branch?

Briefly describe duties and skills acquired through military service: (include dates)

EMPLOYMENT

1. **Begin with most recent employer.**
2. **List ALL present and past employment or military service that the space will allow.**

FROM Mo.	FROM Yr.	TO Mo.	TO Yr.	EMPLOYER NAME & ADDRESS	PAY RATE	POSITION	DUTIES & REASON FOR LEAVING
				SUPERVISOR'S NAME/PHONE NUMBER			
				SUPERVISOR'S NAME/PHONE NUMBER			
				SUPERVISOR'S NAME/PHONE NUMBER			
				SUPERVISOR'S NAME/PHONE NUMBER			
				SUPERVISOR'S NAME/PHONE NUMBER			
				SUPERVISOR'S NAME/PHONE NUMBER			

APPLICANT'S CERTIFICATION AND AGREEMENT

I hereby certify that the facts set forth on this application are true and complete to the best of my knowledge. I understand that:

if employed, false statements on this application may be considered sufficient cause for discharge.
before employment I will be required to submit proof of citizenship.
I meet the minimum statutory age requirements for the position for which I am applying.
my employment will be contingent on the receipt of references considered satisfactory by St. Peter's Hospital.
my employment will be contingent upon satisfactory completion of a 180 day probationary period.
I may be scheduled for any shift or work unit necessary in order to properly staff the hospital.

I hereby authorize the release of any employment information requested by St. Peter's Hospital.

Signature: _____

The Age Discrimination in Employment Act of 1967, as amended, prohibits discrimination on the basis of age.

Authorization for Release of Information

(Carefully read this authorization to release information about you, then sign and date in black ink. You may retain a copy for your records)

St. Peter's Hospital regularly performs reference checks for individuals who we are considering hiring. This release allows our staff and the company we hire to assist us to complete this process. Please review the following authorization about you, and then sign, date, and complete the requested information.

I authorize St. Peter's Hospital, through their agent, Orion International Corporation, to obtain information related to past employment and school activities from individuals, schools, employers, criminal justice agencies, motor vehicle/registration departments, professional licensing registries, or other relevant sources of information.

This information may include, but is not limited to, information about my academic, achievement, performance, attendance, disciplinary, employment history, criminal history record information, and driving and motor vehicle record.

I authorize Orion International Corporation to disclose the record of my background investigation to St. Peter's Hospital

I authorize custodians of records and other sources of information pertaining to me to release such information to Orion International Corporation regardless of any previous agreement to the contrary. I release St. Peter's Hospital, its officers, employees, and agents, from any liabilities resulting from release of such information.

Copies of this authorization that show my signature are as valid as the original release signed by me. This authorization is valid for one (1) year from the date signed or upon my termination of employment with
St. Peter's Hospital, whichever is sooner.

Signature: _____ **Date:** _____

Full Name (Print legibly): _____

Other names used: _____

Current address: _____

_____

Home Phone: _____ **Work Phone:** _____

Date of Birth: _____ **Place of Birth:** _____

Social Security Number: _____